MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09444

172

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County: Harford

City or town: Conowingo – Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Susquehanna River

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pa. County:

City or town: Stewartstown Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: EZRA MILTON AMSPACHER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna A. Amspacher

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 6 1900

8. AGE:

Years	Months	Days	If less than one day
48	8	24	hrs. min.

9. Birthplace: York Co Pa
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER
12. Name: Stephen Amspacher
13. Birthplace: York Co Pa

MOTHER
14. Maiden name: Maude Miller
15. Birthplace: York Co Pa

16. Informant: Wm Amspacher
Address: Stewartstown Pa

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Oct 3, 1948
(month) (day) (year)

Cemetery or crematory: Stewartstown Pa

Location: Stewartstown Pa

18. Funeral director: H Howard Hoke

Address: Fawn Grove Pa

19. Oct 1, 1948 (Date rec'd by registrar) C. M. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 30 1948, at 1:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
DROWNING – ACCIDENTAL	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of injury: Sept 30, 1948

Where did injury occur? Conowingo (City or town) Harford (County) Md (State)

Injured at home, farm, industry, public place (where?): Susquehanna River

Means of injury: Boat Capsized Injured at work? Yes

23. SIGNATURE: J. H. Ramsey M.D.
Deputy Medical Examiner

Address: Aberdeen, Md. Date signed: 10/1/1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

P9445

Reg. Diat. No. 181

1. PLACE OF DEATH:

County: Harford

City or town: Aberdeen - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural - Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Caroline T. Bowser

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband ~~or wife~~: Robert L. Bowser

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 15th 1890

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
57	8			

9. Birthplace: Perryman, Harford Co. Md. (Town, county, and state)

10. Usual occupation: At home

11. Industry or business:

FATHER — 12. Name: Jacob Monk

13. Birthplace: Perryman Md

MOTHER — 14. Maiden name: Elsie Williams

15. Birthplace: N. Carolina

16. Informant: Mrs. Mary Elliott

Address: Aberdeen, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 10 1948 (month) (day) (year)

Cemetery or crematory: Union M. E.

Location: Near Aberdeen, Md.

18. Funeral director: Henry Tarring & Sons

Address: Aberdeen Md

19. Sept 10 1948 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 7 1948, at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 30 1948 to Sept 7 1948 and that I last saw h[illegible] alive on Sept 6 1948

Immediate cause of death: Congestive Heart Failure — Duration: 10 days

Due to: Chronic Hypertension — ?

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Daniel D. Dolac, M.D. M. D. or other

Address: Havre de Grace, Md. Date signed: Sept 9, 1948

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 72 hours
Hospital, institution, or street address (where death occurred): Harford Memorial Hosp.
How long in hospital or institution? 72 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2417 Mc Elderry.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Joseph Carrol Bradley. | **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married

6.(b) Name of husband or wife: Mary Ann Bradley
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 20 1822.

8. AGE: Years	Months	Days	If less than one day
26	1	21	hrs. min.

9. Birthplace: Balto. (Town, county, and state)
10. Usual occupation: Ch
11. Industry or business: Anchor Motor Freight

FATHER
12. Name: Joseph C. Bradley Sr.
13. Birthplace: Md.

MOTHER
14. Maiden name: Adalac Gynhart
15. Birthplace: Balto. Md.

16. Informant: Mrs J. C. Bradley Jr.
Address: 2417 Mc Elderry St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/24/48 (month) (day) (year)
Cemetery or crematory: London Park
Location: Balto. Md.

18. Funeral director: William Cook Inc.
Address: 1217 St. Paul St.

19. 9/24 1948 (Date rec'd by registrar) AW Hedrick DM Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 20 1948, at 325 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Pulmonary Embolism.	
Due to Compound Avulsive Fracture Rt. Femur & fracture	
Due to B 5-6-7 Rib Left Axillary line	
Other conditions (Diabetic)	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide or homicide? Accident Date of 9-17-48
Where did injury occur? Port Deposit Cecil Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Route 222.
How was injury caused? Pick up Truck. Injured at work? yes

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner for Cecil County
M. D. or other
Address: Rising Sun Md. Date signed 9-20-48

VS-A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

09447

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:

County: Harford Co

City or town: Bel Air (Rural) (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Harford

City or town: Rural - Bel Air (If outside city or town limits, write RURAL and give nearest town)

Street No.: Onsbarn (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mawda Bush

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	W.

6.(b) Name of husband or wife: Emory Bush

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 6 - 1877

8. AGE: Years	Months	Days	If less than one day
70			hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: Harry Scott

FATHER — 13. Birthplace: Cola.

MOTHER — 14. Maiden name: Mary Smith

MOTHER — 15. Birthplace: Cola.

16. Informant: Clark Fitzpatrick

Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 24/48 (month) (day) (year)

Cemetery or crematory: County Home

Location: Near Bel Air, Md

18. Funeral director: Jos T Foster

Address: Bel Air Md

19. 9/24 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 23 1948 at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 - 1947 to Sept 23 1948 and that I last saw her alive on Sept 19 1948

Immediate cause of death	DURATION
Chr. Myocardial Disease	2 yr.
Due to	
Due to	
Other conditions: Chr. Cardio Vascular Renal Disease.	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other

Address: Forest Hill Md Date signed: 9/23/48

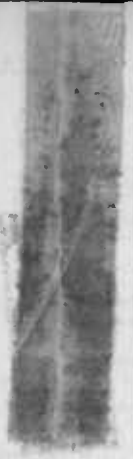
M

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



1881
6y
7m

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

95b

09448

Reg. Dist. No. 182

1. PLACE OF DEATH:

County: Harford

City or town: Cherry Hill Street Rd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Cherry Hill Street Rd

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Walter Jeoi Crowl

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Eva Crowl

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Apr 21 1881

8. AGE: Years	Months	Days	If less than one day
67	4	21	...hrs. ...min.

9. Birthplace: Thomas Run Harford Co

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: James M Crowl

13. Birthplace: Harford Co md

MOTHER — 14. Maiden name: Caroline J Coale

15. Birthplace: Churchville md.

16. Informant: Mrs Eva Crowl

Address: Street md

17. (Burial, cremation, or removal. Which?) Hopkland Date thereof: Sept 15, 1948 (month) (day) (year)

Cemetery or crematory: Hopkland

Location: Street md

18. Funeral director: Martin Ekenz

Address: Churchville Md.

19. 9/14 1948 P Forwood

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 12 1948 at 7-28 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1943 to September 12 1948 and that I last saw h... alive on September 12 1948

Immediate cause of death	DURATION
Coronary occlusion	
Due to: coronary sclerosis	
Due to:	
Other conditions: Rheumatic heart	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D. or other

Address: ARDIFF Date signed: 9-12-48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09449

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH

County: Harford

City or town: Bel Air (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Rural - Bel Air

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Bynum

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Nancy Mellidy Divers

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	W	M.

6.(b) Name of husband or wife: Wm. A. Divers

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): June 22, 1886

8. AGE:

Years	Months	Days	If less than one day
62	2	13	...hrs. ...min.

9. Birthplace: Franklin Co. Va.

(Town, county, and state)

10. Usual occupation: House-Wife

11. Industry or business

FATHER

12. Name: London Price

13. Birthplace: Franklin Co-Va

MOTHER

14. Maiden name: Mary Jones

15. Birthplace: Franklin Co. Va

16. Informant: Mrs Clara Cox

Address: Forest Hill, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 8 1948 (month) (day) (year)

Cemetery or crematory: Fairview

Location: nr Forest Hill, Md

18. Funeral director: Martin L. Kurtz

Address: Jarrettsville, Md.

19. 9/7 1948 P Howard

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 5 1948, at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3 1948, to Sept 5 1948 and that I last saw h.. alive on Sept 4 1948

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	56 hr.
Due to	
Due to	
Other conditions: Essential Hypertension	15 yr.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M.D. M. D. or other

Address: Forest Hill Md. Date signed: 9/6/48

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09450

184

CERTIFICATE OF DEATH

Reg. Diat. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Aberdeen Proving Ground, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Michaelsville, APG, Md.

How long in hospital or institution? DOA

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Annrundal

City or town: Landsdowne
(If outside city or town limits, write RURAL and give nearest town)

Street No. 212 Second Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME

JOHN C. DONDERO

3.(b) Social Security Number

220-22-0922

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Marie Pastarnokas Dondero

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 1, 1885

8. AGE: Years	Months	Days	If less than one day
63	6	19	..... hrs. ..... min.

9. Birthplace: Boston, Massachusetts
(Town, county, and state)

10. Usual occupation: Bomb Disposal

11. Industry or business: APG, Md.

FATHER
12. Name: Bartholemew Dondero
13. Birthplace: Jenoa, Italy

MOTHER
14. Maiden name: Theresa -
15. Birthplace: Jenoa, Italy

16. Informant: Dan Peek

Address: Aberdeen, Maryland

17. Burial, Cremation, or removal. Which?: Burial Interment Date thereof: Sept. 23, 1948 (month) (day) (year)

Cemetery or crematory:

Location: Boston, Mass.

18. Funeral director: Henry Tarring & Sons.

Address: Aberdeen Maryland

19. Sept. 21 19 48 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19 Sept 19 48 at 2 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from D.O.A. 19 ..... to 19 .....

and that I last saw h..... alive on 19 .....

Immediate cause of death	DURATION
Partial decapitation	
Traumatic	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 19 Sept

Where did injury occur? A.P.G. Aberdeen Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Industry APG

Means of injury: Hit by shell fragment Injured at work? Yes

23. SIGNATURE: Robert T. Ford Capt. MC
M. D. or other

Address: Station Hosp. APG. Md. Date signed: 20 Sept.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09451

93d

Reg. Dist. No. 183

1. PLACE OF DEATH:
County: HARFORD
City or town: RURAL - JARRETTSVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 37 years
Hospital, institution, or street address where death occurred:
SAME
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND. County: HARFORD
City or town: RURAL - JARRETTSVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No.: NEAR Cooptown
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Annie Mary Ellis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles Edward Ellis
6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Feb. 8, 1880

8. AGE: Years	Months	Days	If less than one day
68	7	22	...hrs. ...min.

9. Birthplace: Sharon - Harford, Md.
(Town, county, and state)
10. Usual occupation: Housewife.
11. Industry or business:

FATHER
12. Name: Thomas Franklin Bay
13. Birthplace: Harford Co.

MOTHER
14. Maiden name: Rebecca Arthur
15. Birthplace: Har. Co.

16. Informant: Charles E. Ellis
Address: Forest Hill, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 2, 1948 (month) (day) (year)
Cemetery or crematory: Rock Waters memorial
Location: Cooptown Harford Co Md
18. Funeral director: Martin E Hunt
Address: Jarrettsville Md.

19. Oct. 2 1948 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 30, 1948 at 12 30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to Sept. 30, 1945 and that I last saw her alive on Monday - Sept 27, 1945

Immediate cause of death	DURATION
Hypertensive Cerebro vascular disease	5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles E Neff M.D.
M. D. or other
Address: Street, Md. Date signed 9-30-48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09452

47d

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:
County Harford
City or town Edgewood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Edgewood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lilburn E Evans

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Gertrude D. Evans
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1875

8. AGE: Years	Months	Days	If less than one day
73	0	9	hrs. ..... min.

9. Birthplace Hunden, Balto Co, Md (Town, county, and state)
10. Usual occupation Retired Carpenter + Builder
11. Industry or business

FATHER
12. Name John A Evans
13. Birthplace Upper Falls, Balto Co, Md

MOTHER
14. Maiden name Margaret J. Benjamin
15. Birthplace Maryland

16. Informant Mrs Gertrude D. Evans
Address Edgewood Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 15, 1948 (month) (day) (year)
Cemetery or crematory Lorraine Park
Location Baltimore Maryland

18. Funeral director Howard E. McComas & Son
Address Aberdeen Maryland

19. Sep 14 1948 Marie M. Mondedale
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1948 at 10 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-5 1948 to 9-12 1948 and that I last saw h... for ...alive on 9-11 1948

Immediate cause of death	DURATION
Neoplasm of Lung.	1 yr. ?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Fred V Hodous M. D. or other
Address Edgewood, Md Date signed 9-13-48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

09453

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95b

CERTIFICATE OF DEATH

Reg. Dist. No. 162

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Bel Air

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Entire life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Bel Air

(If outside city or town limits, write RURAL and give nearest town)

Street No. 111 Alice Anne St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Janie Rebecca Fisher

3.(b) Social Security Number None

4. Sex: Fem

5. Color or race: Negro

6.(a) Single, married, widowed, or divorced: divorced

8.(b) Name of husband or wife: James Fisher

8.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): Aug 7, 1904

8. AGE: Years: 44 Months: — Days: 28 If less than one day: ...hrs. ...min.

9. Birthplace: Harford Co. Md (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER 12. Name: Samuel Taylor

FATHER 13. Birthplace: Harford co. Md

MOTHER 14. Maiden name: Adeline Jackson

MOTHER 15. Birthplace: Harford Co. Md

16. Informant: Adeline Taylor

Address: 111 Alice anne St Bel Air Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 8 1948 (month) (day) (year)

Cemetery or crematory: Hendon Hill

Location: Near Waterville Md.

18. Funeral director: Elmer E Bullock

Address: 536 Towne St. Havre de Grace, Md

19. 9/7/48 19... P. Tarwood (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 4 1948 at 11:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1. 1945 to Sept 4 1948 and that I last saw her alive on Sept 2 1948

	DURATION
Immediate cause of death: CORONARY OCCLUSION	3 hr.
Due to: Terminating	
Due to: Chr. Rheumatic Heart	
Due to: Disease	15 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other

Address: Forest Hill, Md Date signed: 9/4/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09454

108

CERTIFICATE OF DEATH

Reg. Diat. No. 182

1. PLACE OF DEATH:

County Harford

City or town Street, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Street, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Corbin A. Grafton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Carrie A. Grafton

6.(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Oct. 27 - 1866

8. AGE: Years	Months	Days	If less than one day
81	10	20	hrs. min.

9. Birthplace Harford Co. Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Corbin M. Grafton

FATHER 13. Birthplace Harford Co Md.

MOTHER 14. Maiden name Elizabeth Pyle

MOTHER 15. Birthplace Dublin, Md.

16. Informant Carrie A. Grafton

Address Street, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 19-1948 (month) (day) (year)

Cemetery or crematory Southern cemetery

Location Dublin, Md.

18. Funeral director Hubert F. Hopkins

Address Delta, Pa.

19. Sept 18, 1948 C. W. Kirk (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16, 1948 at 8 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 12, 1948, to September 16, 1948 and that I last saw h[illegible] alive on September 15, 1948

Immediate cause of death	DURATION
(a) Lobar pneumonia	
Due to (b)	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address CAIRDIFF Md. Date signed Sept 16, 1948

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09455

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 186

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

I

7

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 79 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 855 Otsego

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: George Henry Hamby

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth data of deceased (mo., day, yr.): April 1, 1869

8. AGE: Years	Months	Days	If less than one day
79	5	22	hrs. min.

9. Birthplace: Havre de Grace (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: John Hamby

13. Birthplace: Harford Co. Md.

MOTHER 14. Maiden name: Elizabeth Wright

15. Birthplace: Pa.

16. Informant: Mrs. Carrie Wilson

Address: 855 Otsego

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/26/48 (month) (day) (year)

Cemetery or crematory: Angel Hill

Location: Havre de Grace

18. Funeral director: Pennington & Son

Address: Havre de Grace

19. Sept. 25 1948 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 23 1948, at 4-45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 22 1948 to Sept 23 1948 and that I last saw him alive on Sept 22 1948

Immediate cause of death	DURATION
Acute Coronary Occlusion	
Due to: Arteriosclerosis of Coronary Artery	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Stella Impoccia M. D. or other

Address: 200 North Union Date signed: 9/24/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157e 09456

CERTIFICATE OF DEATH

Reg. Diat. No. 185-

1. PLACE OF DEATH: County Harford (C) City or town Havre de Grace. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hr.

Hospital, Institution, or street address where death occurred: Harford Memorial Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Cecil.

City or town (Rural) Perryville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME: MINNIE MAE ~~Baby~~ Harris.

3. (b) Social Security Number

4. Sex: Female

5. Color or race: Col

6.(a) Single, married, widowed, or divorced: Infant.

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Sept 17-1948-

8. AGE: Years | Months | Days | If less than one day: 1 hrs. 40 min.

9. Birthplace: Havre de Grace, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Rufus Harris -

13. Birthplace

MOTHER 14. Maiden name: Thelma Yronay -

15. Birthplace: Virginia -

16. Informant: Thelma Harris

Address: Perryville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 1948 (month) (day) (year)

Cemetery or crematory: Cokesbury

Location: Post Office Churchville Md. Rural

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. Sept. 18 1948 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18 1948; at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 17 1948 to Sept 18 1948 and that I last saw h... alive on Sept 18 - 1948.-

Immediate cause of death	DURATION
Premature - 8 months -	
Due to	
Due to	
Other conditions Anencephalus	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. W. Benson M.D. M. D. or other

Address Port Deposit Md. Date signed 9/18/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

09457

(1-10)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

182

CERTIFICATE OF DEATH

Reg. Diat. No. [illegible]

1. PLACE OF DEATH:

County Harford

City or town Fallston

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Harford Co

City or town Fallston

(If outside city or town limits, write RURAL and give nearest town)

Street No. R. F. D. 2

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anna Hrubes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Charles Hrubes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 4 1890

8. AGE: Years	Months	Days	If less than one day
58	6		..... hrs. ..... min.

9. Birthplace Czechoslavakia (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER

12. Name Joseph Vyoralek

13. Birthplace Bohemia

MOTHER

14. Maiden name Not known

15. Birthplace Bohemia

16. Informant Charles Hrubes

Address Fallston R. F. D. 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 6/48 (month) (day) (year)

Cemetery or crematory Oak Hill

Location Baltimore Md

18. Funeral director Frank Coach & Son

Address 900 N. Chester St.

19. Sept 6 1948 (Date rec'd by registrar) Hugh E. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1948, at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 16 1948, to Sept 4 1948

and that I last saw h... alive on Sept 4 1948

	DURATION
Immediate cause of death: Coronary occlusion	3 weeks
Due to: Essential hypertension	9 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Ted O Hodson M. D. or other

Address Edgewood, Md Date signed Sept 4 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

09458

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

CERTIFICATE OF DEATH

Reg. Diat. No. 185-

M

1. PLACE OF DEATH:
County HARFORD
City or town HAVRE DE GRACE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
HARFORD MEMORIAL HOSPITAL
How long in hospital or institution? 2 MONTHS 8 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Whiteford
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME ROSE LEE KAHOE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	WIDOWED

6.(b) Name of husband or wife JAMES KAHOE (DECEASED) 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct 15, 1863

8. AGE: Years 84 | Months 10 | Days 29 | If less than one day ____ hrs. ____ min.

9. Birthplace Indiana (Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name Joseph Lee.
13. Birthplace Pennsylvania
14. Maiden name Susan Wilson
15. Birthplace Pennsylvania

16. Informant Mrs. Edward Hollahan
Address 712 Union Ave., Havre de Grace, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 18 48 (month) (day) (year)
Cemetery or crematory St Mary's
Location Pylesville Md.

18. Funeral director H. P. Hankins
Address Delta, Pa.

19. Sept. 15 48 (Date rec'd by registrar) C. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Sept 1948 at 11 54 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 6 July 1948 to 14 Sept 1948 and that I last saw h[illegible] alive on 14 Sept 1948

Immediate cause of death	DURATION
RESPIRATORY FAILURE	
Due to TERMINAL HYPOSTATIC PNEUMONIA	
Due to	
Other conditions DIABETES MELLITUS, ARTERIO-SCLEROSIS, FRACTURE OF RIGHT HIP. (Include pregnancy within 3 months of death)	

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 7/6/48
Where did injury occur? Whiteford (City or town) (County) Md (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Fall Injured at work?

23. SIGNATURE R B Norment M. D.
M. D. of other
Address Havre de Grace Date signed 14 Sept 48

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and is especially important. Physicians: please write the causes of death clearly and legibly.

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09459

159

Reg. Dist. No. 185

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1. PLACE OF DEATH:

County: Harford

City or town: Havre De Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hours 10 min.

Hospital, Institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution? 2 hours 10 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

Street No.: General Delivery

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Kell Johnny Jay

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 27-1948

8. AGE: Years — Months — Days — If less than one day: 2 hrs. 10 min.

9. Birthplace: Havre De Grace, Harford, Maryland (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business: I

FATHER

12. Name: Tildon - Morgan

13. Birthplace: Not Known

MOTHER

14. Maiden name: Kell, Effie Ethel Louise

15. Birthplace: Havre De Grace, Maryland

16. Informant: Kell, Effie Ethel Louise (mother)

Address: Aberdeen, General Delivery, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 29-1948 (month) (day) (year)

Cemetery or crematory: Union M. E.

Location: Near Aberdeen md.

18. Funeral director: Henry Tawney Sons

Address: Aberdeen md

19. 9-28 19 48 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 27 September 1948 at 9:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 27 1948 to Sept 27 1948 and that I last saw him alive on Sept 27 1948

Immediate cause of death	DURATION
Prematurity	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Lyle Urchert M.D. M. D. or other

Address: Havre de Grace Md Date signed: Sept 27

09460

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 7 yrs.
Hospital, institution, or street address where death occurred:
13 Liberty St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 13 Liberty St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Stella F. Kelsey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Charles E. Kelsey
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 25th 1871

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
76	8			

9. Birthplace: New York State
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business

FATHER
12. Name: Rowland Buell
13. Birthplace: New York

MOTHER
14. Maiden name: Angeline W. Brown
15. Birthplace: New York

16. Informant: Mrs. Florence B. Heitle
Address: #13 Liberty St.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept. 13-48 (month) (day) (year)
Cemetery or crematory
Location: Wellsville N. Y.
18. Funeral director: Henry Farrington Sons
Address: Aberdeen, Md.

19. Sept 11 18 48 (Date rec'd by registrar) Nellie F. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 10th 19 48 at 11:15 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/1 19 48 to 9/10 19 48 and that I last saw h.r alive on 9/10 19 48

Immediate cause of death	DURATION
Carcinoma of gall bladder and of stomach	8 months
Due to	
Due to	
Other conditions: Multiple deficiency State due to prolonged vomiting (Include pregnancy within 3 months of death)	4 weeks

Major findings of operations: Carcinoma of gall bladder and of stomach Date of op. May 25, '48
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Peter P. Rothman, M. D.
M. D. or other
Address: Aberdeen, Md. Date signed 9/11/48

09461

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Harford Bel Air R.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: HARFORD
City or town: -RURAL- Bel Air
(If outside city or town limits, write RURAL and give nearest town)
Street No.: BOOTH-PLACE.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Ella Virginia Mahoney

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: J. F. Mahoney
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 22, 1858

8. AGE:

Years	Months	Days	If less than one day
89	9	15	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:
FATHER 12. Name: Charles W. Harvard
13. Birthplace: Maryland
MOTHER 14. Maiden name: Harriet James
15. Birthplace: Maryland
16. Informant: Miss Grace Kyle
Address: Bel Air R.D. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 9, 1948 (month) (day) (year)
Cemetery or crematory: St. Ignatius
Location: Hickory Maryland
18. Funeral director: Howard E. McComas Son
Address: Abingdon Maryland
19. 9/8 1948 P Fowood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7 1948, at 8:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1945, to Sept 7 1948
and that I last saw h[illegible] alive on Sept 6 1948

Immediate cause of death	DURATION
LOBAR PNEUMONIA	16 hrs.
Due to:	
Due to:	
Other conditions: Chr. Cardio-Vascular Disease	?

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M.D.
M. D. or other
Address: Forest Hill, Md Date signed: 9/7/48

Mrs. MacDonald

09462

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

CERTIFICATE OF DEATH

Reg. Dist. No. 180

M

1. PLACE OF DEATH:
County Harford
City or town Rural, Edgewood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Intersection of Rt #40 & Edgewood Rd.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Texas County Houston
City or town Whitesboro
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt # 2
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Wayne B. Melson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Single

6.(b) Name of husband or wife None
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 9th 1929

8. AGE: Years	Months	Days	If less than one day
19	3	9	hrs. min.

9. Birthplace Whitesboro, Texas
(Town, county, and state)
10. Usual occupation Soldier
11. Industry or business Unknown
FATHER 12. Name Unknown
13. Birthplace Unknown
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown
16. Informant U.S. Army
Address Army Chemical Center, Maryland
17. Removal Date thereof 9 7 48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Hassel and Foster Funeral Home
Location Palestine, Texas
18. Funeral director Lilly and Zeiler, Inc.
Address 403 S. Wolfe St. Balto. 31, Md.
19. 9/7 1948 A.W. Hedrick Deputy Registrar
(Date rec'd by registrar)

I

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1948 at 10 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Compound Fracture of Skull	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 9/3/48
Where did injury occur? near Edgewood (City or town) Harford (County) Md. (State)
Injured at home, farm, industry, public place (where?) Public Road
Means of Injury Struck By truck Injured at work? No

23. SIGNATURE J.T. Ramsey M.D.
Deputy medical Examiner (M.D. or other)
Address Aberdeen, Md. Date signed 9/3/48

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

8 - 32

1948 - 8 - 3

1 - 3 - 9

1949 - 3 - 24

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

09463

CERTIFICATE OF DEATH

Reg. Diat. No. 182

I. PLACE OF DEATH:

County Harford

City or town Rural Joppa Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Hasford

City or town Joppa. Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Rose Margaret Middendorf

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife Charles A. Middendorf

6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Dec. 4 - 1877.

8. AGE: Years	Months	Days	If less than one day
70	9	1	hrs. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Joseph A. Klug.
13. Birthplace Baltimore Md

MOTHER
14. Maiden name Barbara Bhreck
15. Birthplace Baltimore Md

16. Informant C Las. A. Middendorf
Address Joppa Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 8 1948 (month) (day) (year)

Cemetery or crematory Jerusalem Christian Cemetery

Location Joppa Md.

18. Funeral director W.T. Archer

Address Benson Md.

19. 9/6 1948 P Foxwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5, 1948 at 10:40 A.M. D.T.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 8 1948 to Sept 5, 1948

and that I last saw her alive on Sept 4, 1948

Immediate cause of death	DURATION
Congestive Heart Failure	7 da.
Due to Coronary Sclerotic Heart Disease	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clifford F. Hudson, M.D.
M. D. or other

Address Fork Md. Date signed 9/5/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09464

160C

CERTIFICATE OF DEATH

Reg. Diat. No. 185

1. PLACE OF DEATH:

County: HARFORD

City or town: HAVRE DE GRACE, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hr + 20 MINUTES

Hospital, Institution, or street address where death occurred:
HARFORD MEMORIAL HOSPITAL

How long in hospital or institution? 1 hr + 20 MINUTES

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MD. County: HARFORD

City or town: BEL AIR, MD
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

BABY GIRL MOFFETT

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	SINGLE

6.(b) Name of husband or wife: ~~WALTER MOFFETT~~

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): SEPT 24, 1948

8. AGE: Years	Months	Days	If less than one day
NEWBORN			1 hrs. 20 min.

9. Birthplace: HARFORD MEMORIAL HOSPITAL
(Town, county, and state)

10. Usual occupation: NEWBORN

11. Industry or business

FATHER
12. Name: Walter Moffett Jr.
13. Birthplace: Chestertown, Md

MOTHER
14. Maiden name: Marie Eileen Hanley
15. Birthplace: Telford, Maryland

16. Informant: Mrs Marie Moffett
Address: Bel Air, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 25 1948 (month) (day) (year)
Cemetery or crematory: Ft Hesbury
Location: Abingdon Maryland

18. Funeral director: Howard K. McComas + Son
Address: Abingdon Maryland

19. Sept. 24 1948 (Date rec'd by registrar) A. L. Lawton M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 24 1948 at 10 40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 24 1948 to — 19..
and that I last saw her alive on Sept 24 1948

	DURATION
Immediate cause of death: Premature Birth	5½ mos
Due to: Premature separation Placenta	12 hr
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Charles J. Foley M.D. or other

Address: Havre de Grace Md. Date signed: 9-24-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09465

159

CERTIFICATE OF DEATH

Reg. Diat. No. 185

1. PLACE OF DEATH:

County HARFORD

City or town HAVRE DE GRACE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
HARFORD MEMORIAL HOSPITAL

How long in hospital or institution? 25 hrs 28 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County HARFORD

City or town DARLINGTON
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war — No

3.(a) FULL NAME ETHEL MARIE ~~BABY GIRL~~ MYERS

3.(b) Social Security Number No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	NEWBORN

6.(b) Name of husband or wife None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 23 Sept 48 9:32 PM.

8. AGE: Years	Months	Days	If less than one day
—	—		25 hrs. 28 min.

9. Birthplace HAVRE DE GRACE, MARYLAND
(Town, county, and state)

10. Usual occupation INFANT M.D.

11. Industry or business —

FATHER
12. Name JAMES ROY MYERS
13. Birthplace HOTSPRINGS, VA

MOTHER
14. Maiden name NORMA PAULINE BAXTER
15. Birthplace WHITESVILLE W. VA.

16. Informant NORMA PAULINE BAXTER MYERS
Address DARLINGTON

17. Burial, ~~cremation, removal~~ Burial Date thereof Sept. 27 1948
(Burial, cremation, removal) (Month) (Day) (Year)

Cemetery or crematory Dublin L. M. Cem.

Location Harford Co. Md.

18. Funeral director H. D. Bailey

Address Darlington, Md.

19 Sept. 25 1948 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 SEPT 1948 at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 Sept 1948, to 24 Sept 1948

and that I last saw h...ative on ..... 19.....

Immediate cause of death RESPIRATORY FAILURE — DURATION

Due to.....

Due to.....

Other conditions PREMATURITY — PERIOD OF GESTATION 28-30 wks
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R B Moment M.D.
M. D. or other

Address Havre de Grace Date signed 9-25-48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09466

462

Reg. Diat. No. 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: HARFORD

City or town: EDGEWOOD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Edgewood

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: WILLIAM THOMAS O'BRIEN

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Gladys Marion O'Brien 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 1 1892

8. AGE:

Years	Months	Days	If less than one day
56	0	6	hrs. min.

9. Birthplace: Hartford Conn. (Town, county, and state)

10. Usual occupation: Retired Soldier, U.S. Army

11. Industry or business

FATHER 12. Name: John O'Brien

13. Birthplace: Hartford Conn.

MOTHER 14. Maiden name: Margaret Donahue

15. Birthplace: Hartford Conn.

16. Informant: Mrs. Gladys M. O'Brien

Address: 17 Oak St. Edgewood Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 11 1948 (month) (day) (year)

Cemetery or crematory: St. Francis

Location: Abingdon Maryland

18. Funeral director: Howard R. McDorman & Son

Address: Abingdon Maryland

19. Sept 10 1948 (Date rec'd by registrar) Marie M. Mondedale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/7 1948, at 6:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/1 1948, to 9/7 1948

and that I last saw h... I.M. ...alive on 9/7 1948

Immediate cause of death: CARCINOMA OF STOMACH WITH METASTASES — DURATION: 7/4 Mos.

Due to:

Due to:

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: INOPERABLE STOMACH CARCINOMA Date of op. 2/19/48

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. W. Stewart Jr. M.D. M. D. or other

Address: EDGEWOOD, MD. Date signed 9/7/48

09467

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

100 b

Reg. Diat. No. 181

1. PLACE OF DEATH:

County: Harford

City or town: Aberdeen (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 hours

Hospital, institution, or street address where death occurred: Station Hospital, Aberdeen Proving Ground, Md.

How long in hospital or institution? 23½ hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: ~~Eastville~~ Earlville (If outside city or town limits, write RURAL and give nearest town)

Street No. Woodlawn Farm (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: EMILY AGNES RANDLE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 29, 1930

8. AGE: Years: 17 Months: Days: If less than one day: hrs. min.

9. Birthplace: Easton, Penna. (Town, county, and state)

10. Usual occupation: Student

11. Industry or business

FATHER 12. Name: Edwin H. Randle

FATHER 13. Birthplace: Springfield, Illinois

MOTHER 14. Maiden name: Emily Agnes Kamm

MOTHER 15. Birthplace: Richmond, Indiana

16. Informant: Father of deceased

Address: Woodlawn Farm, Earleville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 10, 1948 (month) (day) (year)

Cemetery or crematory: St. Stevens

Location: Near Earlville Cecil Co. Md.

18. Funeral director: Marvin V. Williams

Address: Chesterton Maryland

19. Sept 9 1948 (Date rec'd by registrar) Nellie F. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 Sept 1948, at 1200 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 Sept 1948 to 8 Sept 1948 and that I last saw h.. alive on 1145 a.m. 8 Sept 1948

Immediate cause of death	DURATION
acute myocardial failure	
Due to: Mechanical obstruction returning 7 Years. Uterus	Birth
Due to: Cesarean Sections (?)	Birth
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Oscar K. Williams M.D. M. D. or other

Address: Aber. Md. Date signed

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107 09468

CERTIFICATE OF DEATH

Reg. Diat. No. 181

1. PLACE OF DEATH:
County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Station Hospital, Aberdeen Proving Ground, Md.
How long in hospital or institution? 50 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. Ideal Trailer Park
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: CAROL MARIE RUSSELL

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 25 February 1948

8. AGE: Years	Months	Days	If less than one day
	7	25	..... hrs. ..... min.

9. Birthplace: Detroit, Michigan (Town, county, and state)
10. Usual occupation: None
11. Industry or business: None

FATHER
12. Name: John E. Russell
13. Birthplace: Detroit, Michigan

MOTHER
14. Maiden name: Maxine Marguartte Russell
15. Birthplace: Texas

16. Informant: John E. Russell
Address: Ideal Trailer Park, Aberdeen, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 21 - 1948 (month) (day) (year)
Cemetery or crematory: Grove
Location: Aberdeen Md.
18. Funeral director: Henry Torring & Sons.
Address: Aberdeen, Maryland.

19. Sept 21 - 1948 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19 September 19 48 at 1035 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 0945 19 Sept 19 48, to 1035 19 Sept 19 48 and that I last saw her alive on 19 September 19 48.

Immediate cause of death	DURATION
Aspiration pneumonia	10 hrs.
Due to: Trauma to chest.	2 days.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results: Same as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Robert E. Lord Capt MC. M. D. or other
Address: Station Hosp. APG, Md. Date signed 20 Sept

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09469

159

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred: Harford Memorial Hosp.

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Street

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME FRANK LEE GRIFFIN SCARBOROUGH

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	INFANT

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) SEPT 27 1948

8. AGE: Years | Months | Days: 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Havre de Grace, Harford Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: FRANK LEE GRIFFIN

FATHER 13. Birthplace: HARFORD Co. Md.

MOTHER 14. Maiden name: HUTTON, MABEL GLEE.

MOTHER 15. Birthplace: DELTA PA.

16. Informant: Mabel Glee Hutton Scarborough

Address: Street Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 2nd 1948 (month) (day) (year)

Cemetery or crematory: Mt Neto

Location: Delta, Pa R D

18. Funeral director: Hubert P. Hankins

Address: Delta, Pa

19. Sept. 29 1948 (Date rec'd by registrar) G. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 Sept 1948, at 3:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 Sept 1948 to 29 Sept 1948

and that I last saw h[illegible] alive on 29 Sept 1948

Immediate cause of death	DURATION
Respiratory failure	
Due to: Fetal atelectasis	
Due to: Prematurity	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: B B Marmen (M. D.)

M. D. or other

Address: Havre de Grace, Md Date signed 9-29-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

09470

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

CERTIFICATE OF DEATH

Reg. Dist. No. 12

1. PLACE OF DEATH:

County HARFORD

City or town BEL AIR
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 YEARS

Hospital, Institution, or street address where death occurred:
RESIDENCE - MAIN ST. BEL AIR, MD.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County HARFORD.

City or town BEL AIR
(If outside city or town limits, write RURAL and give nearest town)

Street No. 21 S. MAIN ST.
(If rural, give LOCATION)

2.(a) If veteran, name war NO -

3.(a) FULL NAME WILLIAM HENRY SPANGLER D.D.S.

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	MARRIED

6.(b) Name of husband or wife NELLIE CATHERINE SPANGLER 6.(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) APRIL 9, 1865

8. AGE: Years	Months	Days	If less than one day
83	4	24	...hrs. ...min.

9. Birthplace WESTERN PORT, ALLEGHANY CO. MD.
(Town, county, and state)

10. Usual occupation DENTIST

11. Industry or business —

FATHER 12. Name GEORGE WASHINGTON SPANGLER

13. Birthplace MARYLAND

MOTHER 14. Maiden name CATHERINE KOONTZ

15. Birthplace MARYLAND.

16. Informant NELLIE C. SPANGLER

Address BEL AIR, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 5, 1948 (month) (day) (year)

Cemetery or ~~XXXX~~ Loudon Park

Location Baltimore, Md.

18. Funeral director D. Howard Strong

Address 3207 W. North Ave.,

19. 9/6 1948 (Date rec'd by registrar) C.W. Aldrick Q.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 SEPTEMBER 1948 at 8:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APRIL 5 1948 to 3 SEPT 1948 and that I last saw h. IM alive on 3 SEPT. 1948

Immediate cause of death	DURATION
UREMIC POISONING	11 DAYS
Due to ADVANCED ARTERIOSCLEROSIS	2 YEARS
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. P. Sudwell M.D. M. D. or other

Address Bel Air, Md. Date signed 9/6/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09471

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:

County: Army Chemical Center

City or town: Edgewood Harford Co.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: D. O. A.

How long in hospital or institution? None D. O. A.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Dallington R.D. Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Box 143

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Stevens Antony

3. (b) Social Security Number: 216-28-0312

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 22 1898

8. AGE: Years: 50 | Months: 5 | Days: 8 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Providence, R.I. (Town, county, and state)

10. Usual occupation: Mechanical Inspector

11. Industry or business

FATHER — 12. Name: Manuel Stevens

13. Birthplace: Azores Islands

MOTHER — 14. Maiden name: Maria Freitas

15. Birthplace: Azores Island

16. Informant: Henry E. Bright

Address: 319 Wilson St. Havre de Grace Md.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Sept 2 1948 (month) (day) (year)

Cemetery or crematory: Martin A. Gleason

Location: 1492 Old Northern Blvd. Glenside, Pa.

18. Funeral director: Howard K. McComas & Son

Address: Abingdon Maryland

19. Sept 2 1948 Mary M. Monksdale

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 September 1948, at 9 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...

and that I last saw h... alive on ..... 19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: W. Conner M.D. Deputy Medical Examiner

Address: Aberdeen, Md. Date signed: 9/1/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09472

170C

CERTIFICATE OF DEATH

Reg. Diat. No. 185

1. PLACE OF DEATH:

County Harford HAVRE DE GRACE

City or town Dale Edgewood Brunswick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? transit

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution? 20 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New Jersey County Camden

City or town Oaklyn

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2 East Haddon Avenue

(If rurol, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Myrna Marie Stone

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of hueband or wife Harrison E. Stone

6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Oct. 7 - 1890

8. AGE: Years	Months	Days	If less than one day
57	11	7	hrs. min.

9. Birthplace Calary Pa. (Town, county, ond state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Shannon

13. Birthplace Penna

MOTHER 14. Maiden name Anna Margaret Lee

15. Birthplace Penna.

16. Informant Robert O. Black

Address 8 Simpson Ave. Pitman N.J.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 18 - 48 (month) (day) (year)

Cemetery or crematory Hillcrest Memorial Park

Location E. Pitman - Washington Twp. N.J.

18. Funeral director Russell E. Weatherby

Address 308 W. Holly Ave. Pitman N.J.

19. Sept. 15 19 48 A. L. Levio M.D. Registrar

(Date rec'd by registror)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1948, at 2:20 P.M.

21. I CERTIFY that death occurred on the date above etated; that I attended deceaeed from ..... 19..... to ..... 19.....

and that I laet saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Shock	
Due to Compound fracture of left leg	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major fiodiogs of operatioos —

Date of op.

Autopsy resolts none

PHYSICIAN: Please uoderline the cause to which death should be charged statistically.

22. VIOLENCE: If death wae due to external cauees, fill in the following:

Accident, suicide, or homicide Accident Date of Sept 14, 1948

Where did injury occur? near Edgewood Harford Md.

(City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) Route # 40 (U.S.)

Meane of Injury Auto accident Injured at work? No

23. SIGNATURE J. H. Causey M.D. Deputy medical Examiner

Address Aberdeen, Md Date signed 9/14/48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

09473

CERTIFICATE OF DEATH

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County Harford
City or town Bel-Air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Bel Air
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME Margratta H Walker

3. (b) Social Security Number No

4. Sex: Female
5. Color or race: White
6. (a) Single, married, ~~widowed, or divorced~~: Married
6.(b) Name of husband: Milton R. Walker
6.(c) If alive, give age: Alive ... years
7. Birth date of deceased (mo., day, yr.): Aug. 10, 1894
8. AGE: Years 54 Months 1 Days 15 If less than one day ... hrs. ... min.
9. Birthplace (town, county, and state): Harford Co. Md.
10. Usual occupation: Housework
11. Industry or business: At Home
FATHER 12. Name: H. M. Hilditch
13. Birthplace: Harford Co. Md.
MOTHER 14. Maiden name: Margaret E. Doyle
15. Birthplace: Baltimore Co. Md
16. Informant: Mr. Milton R Walker
Address: Bel-Air, Md
17. Burial (Burial, cremation, removal): Date thereof Sept 28 1948 (month) (day) (year)
Cemetery or crematory: St Ignatius Cem
Location: Harford Co. Md.
18. Funeral director: H. S. Bailey
Address: Darlington, Md.
19. 9/29 48 (Date rec'd by registrar) Fourwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 19 48 at 11:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2, 1946 19 to Sept. 25 19 48 and that I last saw her alive on Sept. 25, 1948 19

Immediate cause of death	DURATION
Pulmonary Edema (Congestive Heart Failure)	30 min.
Due to	
Due to	
Other conditions Chr. Myocardial Disease	15 yrs.
Essential Hypertension	7 yrs.
(Include pregnancy within 3 months of death) Diabetes Mellitus	10 yrs.

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Willard P. Hudson M. D. or other
Address Forest Hill Md Date signed 9/26/48

09475

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93a

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? IO yrs.
Hospital, institution, or street address where death occurred:
St. Francis Villa
How long in hospital or institution? IO yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Commerce & Market
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sister Mary Cyriana (Wild)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 27, 1861

8. AGE: Years	Months	Days	If less than one day
87	7	29	hrs. min.

9. Birthplace: Switzerland (Town, county, and state)
10. Usual occupation: Teacher
11. Industry or business

MOTHER FATHER
12. Name: Pancoatius Wild
13. Birthplace: Switzerland
14. Maiden name: Agatha Wild
15. Birthplace: Switzerland

16. Informant: Hosp. Records
Address: Havre de Grace, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/28/48 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Baltimore, Md.
18. Funeral director: Cunningham & Son
Address: Havre de Grace, Md.

19. Sept 27 1948 (Date rec'd by registrar) C. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 25 1948 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3 1922 to Sept 25 1948 and that I last saw h[illegible] alive on Sept 25 1948

Immediate cause of death	DURATION
Arteriosclerosis	
Acute myocarditis	
Due to: Acute Pulmonary Oedema	
Due to:	
Other conditions: Cardiac failure	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Charles J. Foley M.D. M. D. or other
Address: Havre de Grace Md. Date signed 9/27/48

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of sex shown on :

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09474

932

FILM No. G 118 DEC 20 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred:

St. Francis Villa

How long in hospital or institution? 10 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Commerce & Market

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Sister M. Nolasca (Wild)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
~~Male~~ Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 8, 1866

8. AGE: Years	Months	Days	If less than one day
82	5	0	hrs. min.

9. Birthplace: Switzerland (Town, county, and state)

10. Usual occupation: House Sister

11. Industry or business

FATHER — 12. Name: Pancoatius Wild

13. Birthplace: Switzerland

MOTHER — 14. Maiden name: Agatha Wild

15. Birthplace: Switzerland

16. Informant: Hosp. Records

Address: Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9/10/48 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Baltimore, Md.

18. Funeral director: Pennington & Son

Address: Havre de Grace

19. Dept. 8 1948 (Date rec'd by registrar) A. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 8 1948, at 10 A M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from July 20 1948 to Sept 8 1948 and that I last saw him alive on Sept 8 1948

Immediate cause of death	DURATION
Chronic Myocarditis	
Arteria Sclerosis	
Due to Senility	
Coma	
Due to	
Other conditions Cardiac Failure	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Charles J. Foley M.D. M. D. or other

Address: Havre de Grace Date signed: 9/9/48

VS-A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09476

159

CERTIFICATE OF DEATH

Reg. Dist. No. 186

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Harford Memorial Hospital.

How long in hospital or institution? 10 hrs 46 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Liberty Grove

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME ~~BABY BOY~~ TIMOTHY LEE WILLIAMS (2nd of TWIN MALES) **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	W	INFANT

6.(b) Name of husband or wife None

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 20 Sept 48 @ 12:27 AM

8. AGE: Years	Months	Days	If less than one day
			10 hrs. 46 min.

9. Birthplace Havre de Grace (Town, county, and state)

10. Usual occupation INFANT.

11. Industry or business

FATHER 12. Name JAMES C WILLIAMS

13. Birthplace Liberty Grove, Md.

MOTHER 14. Maiden name Helen Sasha Shelure

15. Birthplace Darlington, Md

16. Informant James C Williams

Address Liberty Grove, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 21 1948 (month) (day) (year)

Cemetery or crematory West Nottingham

Location Colora, Cecil Co. Md. Rural

18. Funeral director Lee A. Patterson & Son.

Address Perryville, Md.

19. Sept. 20 1948 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Sept 1948 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 Sept 1948 to 20 Sept 1948 and that I last saw h/ alive on 20 Sept 1948

Immediate cause of death	DURATION
Respiratory tract obstruction with mucous	
Due to Prematurity	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R B Norment M.D. M. D. or other

Address Havre de Grace Date signed 9-20-48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING